

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule Query

Topic	Global Procedure Days/Package
Definition	This type of edit will identify incorrect billing when services that are routinely considered part of the global surgery package are reported separately within the preoperative, same day and post-operative days assigned to that surgical procedure code. Consensus on 3/18/12. Consensus on revised definition 7/18/12. This type of edit will identify incorrect billing when an evaluation and management (E&M) service is reported on the same day as a substantial diagnostic or therapeutic procedure (such as diagnostic or therapeutic) procedure. Not applicable as separate edit type, combined with global surgery Consensus 7/18/12.
Associated CPT® ¹ and HCPCS ² modifiers (or codes)	Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period. The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during the postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service
	Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines in the CPT codebook for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used in conjunction with a major surgical procedure (one that has 90 days postoperative follow up) to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.
	Modifier 54: Surgical Care Only. When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to

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the usual procedure code.

Modifier 55: Postoperative Management Only. When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure code.

Modifier 56: Preoperative Management Only. When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure code.

Modifier 57, Decision for Surgery, is used to indicate that an evaluation and management service resulted in the initial decision to perform the surgery. Use of this modifier is limited to procedures with 90-day global periods.

Modifier 58: Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period. The use of the modifier 58 enables the payers to appropriately pay for the procedure per se and other associated postoperative services performed by the original surgeon or provider within or subsequent to its assigned global period (eg, 0 days, 10 days, 90 days). Modifier 58 is used to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure.

Modifier 76, Repeat Procedure or Service by Same Physician, is used to indicate that a procedure or service was repeated subsequent to the original procedure or service in a separate operative session by the same physician.

Modifier 78, Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period. When a procedure is related to the first (but not a repeat procedure) and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.

Modifier 79, Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period. When a procedure or service performed during the postoperative period was unrelated to the original procedure, this circumstance is communicated by appending the modifier 79 to the unrelated procedure.

Query logic

Vendor submission:

- only submit if different than the rule -- CPT/HCPC code, code description, 1 column for preop day (# of days), 1 column for post op days (# of days), 1 column for same day (X), modifier override (Y/N), modifiers allowed to override that differ from policy, effective and end dates, source
- for the codes included in the surgical package there is no public published source. Expect a vendor submission to include the codes included in the package.

Query submission against the MPFS CMS file to evaluate the differences including the values for XXX, YYY, ZZZ

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Rationale	Applying based on Task Force consensus on global procedure days/package. At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions. For services not subject to the global surgical package, see the following: • CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-
DATE	 Up Care for Therapeutic Surgical Procedures, page 58 of CPT codebook. Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package. October 16, 2013



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